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Peter wrote on these two communities as library-led/council initiatives. He says that libraries are becoming increasingly interested in their role in lifelong learning and learning communities, so he hopes his article may have a general interest for libraries and councils. He presented a workshop in Thuringowa on 12–13 October which reviewed the Thuringowa learning audit, and discussed some general aspects of building learning communities. He also gave the keynote address at the annual conference of the Victorian Council of State School Organisations on 15 October which had the interesting theme, "From schools to vibrant learning communities".

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And now it's time to say goodbye – a decade of learning and development in rural and remote health

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The halcyon days of learning and development in New England Area Health Service ended with the 2005 NSW Health restructure. The previous decade had been one of creativity, innovation, risk-taking and major reform. The new order's focus is workforce capability and learning, touting strategic development rather than learning and development per se. What changes are effected remains to be seen.

This paper takes a collage approach to the context and issues that drove innovation and reform in learning in the bush. Apart from providing a single repository for these, the attempt is made to reflect on the worth and value of the journey undertaken. Given the major difference in our approach to learning, compared with that from the other (then) seventeen area health services, the question is asked of our efficacy in transforming the learning culture.

Introduction

Learning and development (L&D) was a devolved responsibility to area health services across NSW Health, having no centralised department or unit within the health department itself. Where previously eighteen L&D Units served the 100,000 workforce, the 2005 health restructure now operates through eight. Significantly, traditional L&D has morphed to strategic workforce capability, as health governance contracts back to the department. Noticeable is the emergence of a new generation of managers.

Hunter New England Health is an amalgam of what were Hunter, New England and part of Mid North Coast area health services. It provides care for 840,000 people, covers a spread of 130,000 square kilometres (the size of England), has 14,500 staff, and a budget of $919m covering some 70 facilities. It is unique in being a mixture of metropolitan (Newcastle), rural and remote. New England Area Health Service, by contrast, had 3,000 staff in 30 facilities across an area the size of Tasmania.

For its last several years, three staff ran L&D in New England Area Health Service, contrasted with eight a decade earlier. At the time of merger, there was but one person remaining. This paper reflects on the journey from *ad hoc* classroom-based teaching and learning, to Vocational Education and Training Accreditation Board accreditation, through a sole focus on vocational education and training (VET), to flexible, online and blended learning. Along the way, a slew of grants, awards and our raft of published research informed this evolution (Mills 2003). Now it is timely to step back and reflect on what was achieved, and the extent to which success was effective and, indeed, worthwhile.

Milestones, themes and chronology

The seminal events and other influences on our journey out of pedagogy are summarised in Table 1.

Table 1 Milestones in the evolution from sole reliance on pedagogy to flexible, blended and online learning: 1995–2005

Year	Significant events
1994	Research and publication strategy endorsed as a quality adjunct
1995	VETAB (Vocational Education and Training Accreditation Board) accreditation achieved following two years of preparation
1998	VET certificates & diplomas became sole focus of L&D
1999	All L&D Units across NSW Health unite under the one Registered Training Organisation
2000	LearnScope grant Flexible learning completely replaced classroom teaching
2001	Reframing the Future grant NSW Health Baxter Award for Embracing Innovation Commendation in Premier's Public Sector Awards
2002	Flexible Learning Leader NEAHS Quality Award for Better Value Online discussion facility rented for communication, support and learning First online course across NSW Health developed and trialled
2003	LearnScope grant Re-accreditation of NSW Health Registered Training Organisation, following successful audit of New England Area Health Service as third and final audit site Withdrew from *all* training to execute strategic organisation development projects New England Area Health Service Quality Award for Education and Training
2004	LearnScope grant New England Area Health Service Quality Award for Education and Training Finalist – NSW Health Baxter Award for Information Management
2005	New England Area Health Service merged with Hunter to become Hunter New England Health *Virtual Class,* online learning management system, created and trialled Finalist – Hunter New England Health Quality Award for Information Management

The seminal event that transformed learning in New England Area Health Service was accreditation. It, initially in our own right as a Registered Training Provider and later as the united and integrated NSW Health Registered Training Organisation, was hugely significant. From 1998 through to 2003, core business for our L&D Unit was management of up to fifteen VET qualifications, notably from the business, community services, and public sector national training packages (Hartley 2000).

Hand-in-hand with the Unit's refocus to VET training was the decisive and strategic move in 2000 to cease all face-to-face teaching and fully embrace flexible learning. Had we continued the then *modus operandi*, we could have, and would have, tied up the complete L&D resource running relatively insignificant soft courses in the classroom, with little measurable return to the organisation (Cupitt 2000).

That flexible learning segued to online delivery was predictable (Mills 2001). The initial decision to forego the classroom was daring for its time, and indeed, New England Area Health Service was the only are health service to have done so. But subsequent grants (LearnScope, Reframing the Future, Flexible Learning Leaders) from the Australian National Training Authority certainly smoothed the journey. More than that, they both led and validated the directional change in our thinking.

The ultimate manifestation of this evolution in thinking and practice was the birth of our very last milestone attributable to what was L&D in New England Area Health Service, namely, the creation of V*irtual Class*, a home-built, online management platform for learning (Hartley & Anderson 2005, in press). Before this, there was no platform for delivering and managing learning anywhere in health, despite NSW Health itself having a workforce of 100,000.

Virtual Class established a benchmark in having standardised learning packages, in one location, for three learning pathways:

- Recognition of Prior Learning (advanced standing)
- Self-directed (online)
- Classroom or tutorial presentation.

Thus, issues of currency, ownership, consistency, accuracy and so on were automatically addressed. The potential for efficiency gain in removing duplication was enormous. This innovation was a truly amazing feat, forged as was our norm, in a resource-poor environment.

The remaining stand-out from Table 1 is the array of awards our work attracted in recent years – some local to New England Area Health Service, others NSW Health-wide and one Public Service-wide. More interestingly still is the menu of categories in which the work was recognised, seldom restricted to categories pertaining to education and training alone, and instead extending to domains covering access, equity, innovation and information management. In other words, there has been considerable objective and external recognition for our vanguard thinking.

What is not so readily apparent from Table 1, however, is the research and publication output from the Unit, which underpinned and showcased our work. During the ten years, more than fifty papers were published by the team, mostly journal articles but some conference and other papers. Whether it was subject-based (Cupitt 1997, Smith 1997, Streeter 1997, Turner & Hartley 1997, Hayes 1999, Owens & Hartley 1999), pedagogical philosophy (Cupitt 2000, Hartley 2001a) or evaluation studies (Hartley *et al*. 2004a, Mills 2003), every aspect of our undertakings was published for others to critically assess, emulate or learn from. In this regard too, as with our focus on flexible and online learning, New England Area Health Service stood alone across NSW Health.

Given the demise now of what would be seen as traditional L&D, and without entering into debate over the directional change presaged

by the recent restructure in health, how might we realistically judge performance of L&D in New England Area Health Service? How might history come to judge what we did, and at what cost to what we in fact did not do?

Reflections

Aggregating the above reduces the discussion to two over-arching and interrelated themes: accreditation and flexibility in learning.

Accreditation

Accreditation first came in 1995, and despite withdrawing from all training a decade later, the gist of the accreditation methodology vaccinated and shaped our thinking on reform in learning. Despite the then Unit's reluctance to assume the mantle of accreditation, the team did come to accept its necessity. We were particularly disadvantaged at the time, the combination of our ignorance of any accreditation frameworks and what they actually meant, and our rurality (Hartley & Garrett 1996).

Back in 1993 when our journey to accreditation began, we were unusual among what were then 'rural districts' across NSW Health, in seeing the need for, and getting, accreditation. We also became the lead proponent in driving the evolution of the single Registered Training Organisation for NSW Health (Hartley 2001b). Because of the relative autonomy among health districts, and subsequent area health services, notions of cooperation and collaboration in L&D were challenging concepts indeed. And while the NSW Health Registered Training Organisation was finally birthed, integrating its management proved yet another challenge, resolving itself some years later, and that forced largely by the re-accreditation auditing process late in 2003.

NSW Health is arguably among the largest registered training organisations in Australia. Its survival to date has depended solely

on the goodwill of L&D managers across health. It's their major achievement in collaboration, and as already indicated, was itself a tortuous journey.

The future of the Registered Training Organisation is now very much at stake. The self-managed *modus operandi* of the Registered Training Organisation, spread across various L&D managers, is quickly disappearing, as their numbers have been halved and most incumbents replaced. Coincidentally, NSW Health itself is starting to show unprecedented interest in the survival of the Registered Training Organisation, previously absent, with many a division's workforce development plan predicated on a viable NSW Health Registered Training Organisation.

With workforce planning now the 'flavour' in health, it seems quite possible the Registered Training Organisation will finally morph into the potentially powerful driver of change across the health workforce that it always might have been. Reflecting on its evolution, it is reasonable to conclude that formidable, visionary and unequivocal change was wrought across health under the rubric of accredited learning, even though, at the time of its (disparate) conception, we ourselves may not have fully understood its future and potential. Nevertheless, there was sufficient astute leadership to tackle the journey and make it happen, despite the fact that some area health services have never provided VET.

As previously flagged, New England Area Health Service withdrew as an active site of the Registered Training Organisation at the end of 2003, immediately upon being the third and last delivery site to have been audited by the Vocational Education and Training Accreditation Board for re-accreditation. This was due to resourcing issues largely, and the need to execute a suite of visionary organisational development projects to provide the scaffolding off which future learning and development might more aptly hang (Hartley *et al.* 2004b). In New England Area Health Service at least, L&D existed

very much in a limbo of its own, not being core business in health, and certainly not integrated across all divisions and functions. One of the big improvements the current restructure across health brings is that it attempts, on paper at least, to integrate more fully this functionality – not that the previous limbo-like existence didn't accrue benefits of its own.

On balance, and with the benefit of hindsight, accreditation was undoubtedly the path to have taken. Nowadays, accreditation of whatever ilk and industry is largely mandated and therefore ubiquitous. Sooner or later it would have been forced upon us any way. The importance and need for standards like compliance with legislation, recognition, access and equity, learning and assessment strategies, and competent L&D staff, simply cannot be argued with any more.

More locally to New England Area Health Service, not only did this period constitute a complete revamp of core business in L&D, in so doing it essentially re-engineered how learning was managed and delivered. That 2,000 instances of accredited short courses, certificates (II, III & IV) and diplomas were issued (to a staff of 3,000) clearly reflected massive change, and more importantly wide-scale adoption of that change. The thrust of running accredited learning, for us, was not so much that learners gained qualifications (important as this was, of course). Rather, that the whole notion of learning itself be challenged and modernised.

Many staff, however, notably those with tertiary education, initially scorned the very notion of VET qualifications, despite aged care (as in an overall aging population) being core business of the health service. However, astute marketing, followed by a domino effect, did result in uptake, albeit slowly at first. What really won over staff was the personal benefits from the newish concepts of recognition of prior learning, articulation to higher qualifications, on-the-job learning and assessment, competence and competencies, flexible, team and self-directed learning, and so on.

Once these concepts were understood and embraced, learning in New England Area Health Service was rejuvenated. There are numerous anecdotal stories of whole-of-facilities, or teams or like-minded individuals working together, sometimes online, towards gaining qualifications. It became evident staff were becoming empowered and excited about lifelong learning, which certainly challenged some managers. Educators in particular, in the early days of our metamorphosis, were challenged by our innovations. Five years later however, they have become the very champions of what we set out to achieve.

Flexibility in learning

As previously indicated, we were the only L&D Unit across NSW Health to totally embrace flexible learning, and in so doing, eschewed all classroom-based teaching, though regular tutorials were run. (Flexible learning for us was something of a blend therefore.) This occurred back in 2000 and was highly controversial at the time. It went hand-in-hand with relinquishing any responsibility for learning other than VET, another facet of development which set us apart from mainstream L&D providers across health.

Interestingly our contraction to dealing with VET qualifications only, in lieu of more traditional L&D functions, caused little discontent among the 3,000 staff. Traditional L&D covered subjects like safety, communications, quality and so on. Orientation, annual mandated in-services and computer training, often included in this suite, had never been our responsibility.

What became apparent over time was the fact that management for generalist-type learning devolved to divisions, facilities and teams. While it was not our specific objective that it occur, this spin-off was welcome nevertheless, and consistent with our philosophy to get staff

excited about and responsible for much of their own learning. What this meant in practice was that, if managers deemed some particular learning or training important to their team's performance, then they sourced and recorded it.

Opposition to our directional changes and innovations was fairly limited, but unbelievably vociferous, largely coming from self-interest groups who foresaw the sweeping change it would mean in their *modus operandi*. What we hadn't anticipated was the irrationality of the antagonists, many of whom were undertaking higher studies in various aspects of pedagogy. It was a tumultuous time for the L&D Unit, who themselves were not entirely united about what was unfurling.

Devolution in responsibility for managing learning is an interesting concept, juxtaposed against notions of centralist control and accountability. Despite New England Area Health Service having purchased *Pathlore*, an integrated management system for learning, only data provided by the L&D Unit itself were ever entered. *Pathlore* was a very under-utilised resource, purchased by most L&D Units across health, one by one. (A decade later, a single purchase would have been possible.)

One of the Unit's organisational development, big-pictured projects previously alluded to was the strategic rollout in use of *Pathlore* so that every manager had carriage of data entry and reporting. Tied into this was to have been revamped position descriptions, including key competencies important to all staff, and from which learning needs could be identified through appraisal and subsequently registered in *Pathlore*. This project went on hold at merger, its fate to be re-examined.

Grants, awards and publication

Our Unit was not unique in attracting its slew of Commonwealth grants dealing with modernising pedagogy, for this was replicated

over many area health services. We were somewhat unusual, however, in attempting the cooperative and collaborative approach in engaging all L&D Units across health in our forays into flexible and online learning, away from the classroom. As had been the case with the accreditation debate, our engagement was troublesome and not particularly productive. For whatever reasons, it was never forthcoming. Having said this however, over time a gradual opening up to experimentation with flexible learning has been detected among other area health services.

What this means, on reflection, is that perhaps we were a little ahead of the herd, as with accreditation. Flexibility in learning is inevitable nowadays. It was never going to be an 'if' debate, simply a 'when'.

Awards are spurious indicators of achievement, at best, not unlike the Oscars in many ways. And not everyone sees value in nominating for them. For us, it was as much about marketing and showcasing our work as winning.

Publishing our work, predominantly in refereed journals, was an objective validation of our contribution to learning. Whereas grants and awards could be contested in terms of the significance they confer, publishing our work could not. This present paper finalises that opus – every aspect of our thinking and practice is now documented in the literature.

And finally …

After leading reform in L&D for over a decade, one thing is certain – it comes at a price and with no guarantee of success. The decade of innovation presented above galvanised opinion, both within New England Area Health Service and, most interestingly, across L&D in NSW Health. Some joined our journey, others actively advocated against it.

Furedi's (1997) sociological perspective on fear has relevance here. He writes about the pervasive culture of fear in organisations and the morality of low expectation, arguing that fear of change limits once-welcomed experimentation, and perpetuates conservatism. All of this is predicated on the risks decision-makers face in adopting change. Increasingly, managers and others seem to want to know the entire risk spectrum before endorsement and adoption, and without these (sometimes unrealistic expectations) being met, change and innovation can get shackled and shelved.

Much of the L&D journey in New England Area Health Service was unplanned, relying very much on the freedom we had to think through issues and solutions, and very much on serendipity. The previously mentioned limbo-like existence enabled considerable freedom in what we did and how. Gaining a Flexible Learning Leader in 2002 opened hitherto unseen worlds to us. And despite the fact of our resources ever diminishing, as in staff and budget, our imaginations took hold of the "what could be possible", especially given our rural and remote location.

For everything we gained from our creativity and innovation nevertheless, we lost equally in not providing the bread-and-butter of traditional L&D, including for example a sound management development program. The fundamental question we faced was how best to use three staff, with very little budget, to meet the learning needs of 3,000 staff. Our focus on flexible learning, more blended in reality, using VET qualifications to introduce the modern (ANTA) learning concepts seemed the logical, and perhaps only, choice.

Whether the direction we took has had any influence on key performance indicators of health's core business, who can tell, without detailed comparative studies benchmarking L&D outcomes among other area health services. Having said this however, it is worth recording that New England Area Health Service never had difficulty throughout its own accreditation cycles, nor did it perform badly against most state-wide performance indicators and benchmarks.

In the final analysis, therefore, perhaps it is simply that L&D in New England Area Health Service was somewhat ahead of its time in trailblazing L&D solutions that would have come to the health workforce inevitably. How much of what we achieved carries on in the new order remains to be seen. But given our innovations were more concept-based than topic-based, it is hard to imagine much being relegated. Irrespective of what happens now, it is unlikely that accreditation standards, flexible and online learning will not continue, now that there are a few more educators only (all metro-centrically based) over an even large geographical spread.

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~~Basic concepts of the educational science sub-discipline of adult education~~

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~~*In this study, a conceptual system is outlined for the educational science sub-discipline of adult education. Adults' attending instruction or not attending instruction is conceptually specified. Focusing as it does on a cardinal event of adult education, this represents a first step toward a system for the educational science sub-discipline of adult education. Attending instruction is mainly understood as action, and non-attending instruction as behavior. Instruction is a system of educational actions in which the teacher orients a subject to the educand in order to change his or her psychic dispositions.*~~

~~If we examine questions of adults' attending or not attending instruction, we find numerous concepts in the relevant literature that are meant to describe this event. These include concepts like~~